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DOCTOR SUPPLY AND MEDICAL EDUCATION

by

Helen B. Shaffer

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RICHARD M. BOECKEL, *Editor*
BUEL W. PATCH, *Associate Editor*

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DOCTOR SUPPLY AND MEDICAL EDUCATION

ACTION to overcome threatened shortages of medical personnel having been pledged by both parties, the new national administration to be installed in January will be in good position to put through a broad program of government support for medical education. If Congress accepts the administration program, as seems likely, it will open up a wholly new area of federal aid to medical schools and medical students.

Over the last dozen years the federal government has helped medical schools indirectly through generous support for research on numerous health problems, but little or nothing has been done to encourage young people to prepare for careers in medicine. Now it is proposed that the government extend assistance in forms directly aimed to increase enrollments for basic medical training.

The 1960 platform of the Democratic party proposed "federal aid for constructing and modernizing schools of medicine, dentistry, nursing and public health . . . [and for] scholarships and other assistance to break through the financial barriers to medical education." The Republican platform called for "federal help in new programs to build schools of medicine, dentistry, public health and nursing and financial aid to students in those fields." Because the stated objectives looked pretty much the same, although the candidates' ways of attaining them would differ, medical education did not become an issue in the presidential campaign.

Increasing Needs for Medical Personnel

The tremendous expansion of public demand for health services of many kinds has been reflected in demands for more professionals in all branches of medicine. The average American now consults a physician twice as often as he did before World War II and the need for doctors in fields other than private practice has risen at a rapidly accelerating rate.

The medical schools must supply not only the general practitioners and specialists needed to serve an increasing population, but also teachers, research workers, public health officers, administrators of health programs, and staff doctors for institutions and industry—all fields which have had spectacular growth in recent years. Thus while the ratio of M.D.'s (excluding osteopaths) to each 100,000 of population rose over the past 30 years from 125 to 132, the ratio of doctors in private practice fell from 108 to 91.

Increased specialization, while made necessary by the accumulation of new medical knowledge, has diminished the potential supply of general practitioners. In 1931 only one doctor in six was a specialist; today nearly half of all doctors restrict their practices to specialties. Training to become a specialist may delay a doctor's entry into practice by as many as six years.

Advances in medical science and in medical care procedures have raised a need for better trained nurses. The American Nurses' Association is now pressing for an increase in the number of nurses with B.A. degrees, because of "the expanded supervisory functions of the registered nurse, brought about by the growth of hospitals and other health agencies and the greatly increased number of non-professional personnel now participating in health services." [1]

The increase in demand for professional medical services is offset in part by the improved efficiency of modern medical practice. New drugs and methods of treatment promote more rapid recovery from acute illness and permit better control of chronic illness. Efficiency of medical practice is said to have been furthered by "improvements in the organization of services, the urbanization of the population, the substitution of office for home visits, the increased use of hospitals, the greater . . . utilization of nurses and other allied medical personnel." [2]

Surveys indicate that the average physician today sees at least 100 patients a week; 30 years ago he saw only 50. But patients complain of the brevity of consultations, and doctors themselves recognize that more leisurely talks with

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[1] American Nurses' Association, statement submitted to House Commerce subcommittee, June 3, 1960.

[2] Department of Health, Education, Welfare, *Physicians for a Growing America* (report of Surgeon General's Consultant Group on Medical Education, October 1959), p. 11.

patients may have therapeutic values. The brisk pace in the doctor's office is largely responsible for the feeling that, while modern medical practice may be more scientific, it lacks some of the "art" typical of the old-time family physician.

Impending Shortages of Doctors, Dentists, Nurses

The Consultant Group on Medical Education[3] reported to the Surgeon General of the U.S. Public Health Service a year ago that the existing supply of 235,000 doctors of medicine and 14,000 doctors of osteopathy, representing a ratio of 141 per 100,000 population, could be considered a "minimum adequate supply." But the group expressed doubt that this ratio could be maintained in future years without bold measures to increase the number of medical students.

The medical schools at present graduate about 7,000 students a year, the schools of osteopathy about 450. The number has been rising at a rate which, if sustained over 15 years, would produce a graduating class of 7,900 by 1975. But this rate of growth would provide only 312,000 doctors and osteopaths in 1975, lowering the present ratio of 141 per 100,000 to 133. To maintain the present ratio, the rate of increase will have to be stepped up enough to produce 11,000 graduates in 1975, thus assuring the nation a total of 330,000 doctors and osteopaths.

A somewhat similar situation prevails in regard to dentists, whose number has risen in recent years but not in proportion to population. Thirty years ago, the United States had 59 dentists to each 100,000 persons; now it has 56. Because more and more dentists are going into government or institutional work, the ratio of private dentists to each 100,000 of population has dropped more sharply—from 58 to 46. There are now nearly 100,000 active dentists in the United States and approximately 3,000 new graduates enter the profession each year. If the output continues at this rate, there will be 118,000 dentists in 1975, but the Consultant Group estimated that the number required 15 years hence to match the present level of supply would be 134,000.

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[3] The Consultant Group was set up by Surgeon General Leroy E. Burney in December 1958 to seek an answer to the question: "How shall the nation be supplied with adequate numbers of well-qualified physicians?" It included medical school officials, other educators, executives of professional organizations, and representatives of industry.

Some 460,000 nurses are in service today—a ratio of 268 per 100,000 of population. If the nursing schools maintain the existing admissions level of 46,000 students a year, the ratio will drop to 246 by 1970. The National League for Nursing has set a minimum goal of 300 nurses per 100,000 of population, which would require a total of 600,000 to 700,000 nurses in service by 1970.

Regional Inequalities in Distribution of Personnel

The distribution of doctors around the country displays striking inequalities. The latest regional survey (1957) showed the highest ratio in the Northeast (161 doctors, exclusive of those in federal service, per 100,000 of population), the lowest ratio in the South (100).[4]

A Southern Regional Education Board survey in 1959 showed Maryland as the only one of 16 southern states with a ratio of doctors to population above the national average. The poorest-supplied states were Mississippi and South Carolina with only 78-79 (exclusive of federal doctors) per 100,000 of population, compared with a national ratio of 129.

The ratio of nurses per 100,000 population, according to 1956 figures, ranged from 336 in the North Atlantic states to approximately 170 in the South, against a national ratio of 258. A 1958 survey of dentists showed a range from 85 per 100,000 in New York to 20 in South Carolina, with a national ratio of 53 per 100,000.

Foreign Physicians on Staffs of American Hospitals

The doctor supply situation would be more worrisome were it not for wide utilization of doctors from abroad. The number of foreign-trained physicians granted licenses to practice in this country rose from 458 in 1950 to 1,316 in 1958. In the latter year, the foreign-trained group constituted 17 per cent of the nation's new licensees.[5]

Dependence on foreign-trained doctors is most evident in the hospitals, particularly in small, non-teaching hospitals which cannot compete successfully for the limited supply of American medical school graduates. Many smaller hospitals advertise abroad for staff personnel.

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[4] Department of Health, Education, Welfare, *Health Manpower Source Book*, Section 9 (1959), p. 10.

[5] An estimated 400 of these were American citizens who had been trained abroad.

Alien interns and resident physicians serving in American hospitals number 8,400. It is not unusual to find a hospital whose entire staff of interns and residents is made up of aliens, many of them in the United States on temporary visas.

The Surgeon General's Consultant Group raised the question of whether a nation as wealthy as the United States should depend on other nations for a substantial part of its doctor supply, in view of the shortages of medical personnel in some of the countries from which aliens have been recruited. "In no other field of education," the group's report stated, "is there a situation in which the United States draws to the same extent on persons educated in other nations to maintain its high level of service."

The influx of aliens has raised questions as to the quality of service in hospitals which depend on foreign-trained staffs. While some foreign schools meet American standards, others do not. Even if well-trained, the alien intern or resident may be handicapped by a poor command of English, which prevents him from understanding fully the complaints of patients or from carrying out explicitly the instructions of the head doctor.

Improved Standards for Doctors From Abroad

A movement to require more exacting standards for foreign doctors coming to the United States began two years ago when four medical organizations[6] created the Educational Council for Foreign Medical Graduates. The council set up semi-annual tests in centers overseas for candidates for internships and residencies in American hospitals. The examination takes many hours and is considered tough, requiring both good medical preparation and a reasonable command of English.

Under a ruling effective last July 1, all foreign applicants for posts in American hospitals must pass the test in their own countries before receiving appointments here. Those already serving in American hospitals were also required to take the test. Of the 8,400 now holding internships and residencies, two-thirds had passed the test by last June. The others were required either to leave their posts by July 1 or (if their grades were close to passing)

[6] American Medical Association, American Hospital Association, Association of American Medical Colleges, and Federation of State Medical Boards.

to take a second test in September. Those failing the second test will be required to quit by Dec. 1. While diminishing the potential supply of medical manpower, the new ruling will assure a higher quality of medical service.

Dr. Dean F. Smiley, director of the Educational Council, predicted last June that the new regulation would cut the annual flow of 3,300 foreign medical school graduates into the United States by about one-half. Hospitals which do not discharge disqualified personnel risk forfeiting American Medical Association approval of their intern and residency training programs.

Expansion of Facilities For Medical Training

TO COPE WITH impending shortages of doctors and other medical personnel requires first, more schools, teachers and teaching equipment; second, some action to encourage more well qualified students to take up the long and difficult study of medicine. Major questions to come before Congress next year will have to do with the extent of federal participation in financing the construction and operation of medical schools and in underwriting the education of medical students.

Federal money has already poured into the nation's medical schools and affiliated institutions in considerable volume, but almost all of it has gone for medical research and training of research workers. The feeling is growing among leaders of the profession that federal aid to date has been unbalanced, that it has favored rapid growth of research and research facilities while neglecting the education of needed practitioners. An official of the Association of American Medical Colleges recently pointed out this imbalance in the government's medical research program, saying:

> We have made vast amounts of money available for research on all the crippling and killing diseases. We have spent huge sums on the development of research personnel and training programs for the young and future researcher. We have put millions . . . into research quarters, but relatively nothing [into] teaching space. . . . Congress has studiously avoided giving any funds that might be applied to education.[7]

[7] L. T. Coggeshall, testimony, House Commerce subcommittee, June 6, 1960.

Currently the nation is spending a total of $711 million a year for medical research, of which more than half is supplied by the federal government. At least one-fourth of all medical research uses the facilities of the medical schools and at least half of the tax funds expended by the National Institutes of Health for medical research programs has been invested in the medical schools.[8]

A recent tally of federal funds received by medical schools (exclusive of research grants and contracts) showed a grand total of $276.5 million over the fiscal years 1950-1961. These funds were used chiefly to finance advanced training of medical school graduates in research techniques and for construction of research facilities.[9] Medical research is, of course, inseparable from medical education, serving not only to advance knowledge but also to train specialists.

A report to a Senate Appropriations subcommittee by its Committee of Consultants on Medical Research noted that "The federal program in support of medical research has given the medical schools of the country the opportunity to build up their research and teaching potential to a strength which could scarcely be imagined 15 years ago." But the consultants added:

> The full development of the present medical education capacity of the country and its expansion to meet the demands of our rapidly expanding population . . . cannot be achieved until federal help of other kinds is forthcoming. . . . Failure to produce doctors in proportion to our rapidly expanding population would court disaster in both the military and civilian sectors . . . and would pose a threat to the national health and welfare which no citizen will tolerate. . . . A major program of health educational facilities construction is absolutely inescapable.[10]

The report of the Senate consultants urged "immediate implementation" of the recommendations of the Surgeon General's Consultant Group on Medical Education. The latter group had recommended that existing federal programs be extended to provide funds for medical school construction, for medical scholarships, and for increases in research grants to cover more adequately the expenses

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[8] Department of Health, Education, Welfare, *A Study of Twenty Medical Schools* (1959), p. 5.

[9] House Appropriations subcommittee on Public Health Service, hearings on appropriations for 1961, p. 465.

[10] Committee of Consultants on Medical Research, *Federal Support of Medical Research* (report to Senate Appropriations subcommittee, May 1960), p. 11.

incurred by the institution in carrying out the research projects.

Recent Growth in Capacity of Medical Schools

A need to build more medical schools persists despite the extensive construction of the past decade. Nearly every medical school has built some new structures since 1950. Eighteen schools recently surveyed by the U.S. Public Health Service had spent $7 million on the average for additional work space. Since 1940, three new private and five new tax-supported schools of medicine have been established, and six two-year "schools of basic medical sciences" have expanded their programs to become full-fledged four-year medical schools granting the M.D. degree.

A compilation by the Association of American Medical Colleges shows expenditures of $1,634 million for construction of medical schools and affiliated institutions from 1948 through 1959. Of this sum $218.3 million was supplied by the federal government in matching contributions. The major part of the total was laid out for hospitals owned by or affiliated with teaching institutions and $43.5 million for research and other facilities used but not owned or operated by the medical schools. Something more than a half billion was spent for construction of medical teaching and research space in universities, of which the federal share was $80.6 million.[11]

The country now has 85 medical schools and six schools of osteopathy. Medical school expansion accounted for a rise in enrollment from 22,000 in 1941 to 26,000 in 1950 and to 29,000 in 1958. Although the size of faculties has doubled, teacher shortages persist; a 1958 study showed vacancies in 6 per cent of 11,000 budgeted full-time faculty positions.

Schools of dentistry experienced a similar growth. More than $60 million was spent on new construction over the past 10 years, adding 1,100 to the freshman capacity of the country's 47 dental schools. There are fewer schools of nursing today than in the 1940s, but an increasing number of colleges and universities are offering baccalaureate programs in nurses' training. The 1,128 nursing schools at present in operation have about 100 students each;

[11] Department of Health, Education, Welfare, *Physicians for a Growing America* (1959), p. 89.

more than three-fourths of the enrollment is in hospitals.[12]

The Surgeon General's Consultant Group estimated that in order to maintain the present level of doctor supply in 1975 it would be necessary to increase the student capacity of the medical schools by 50 per cent. It stressed that a start should be made immediately because it takes 10 years for planned construction to reach the point where additional graduates are turned out. To arrest the decline in the supply of dentists, the Consultant Group said dental school capacity should be expanded to produce 6,180 graduates by 1975 or 2,700 more than could be counted upon with present facilities.

In addition to classrooms and laboratories, medical schools require clinics, research space, good libraries, and living quarters for students. Estimates of the required capital investment for a new medical school range from $30 million to $50 million; the average cost of four-year medical schools built between 1948 and 1959 was $23.4 million.

Billion Dollar Estimate of Needed Construction

The consultants to the Senate Appropriations subcommittee recommended a $1 billion-plus construction program, with the funds to be allocated for three principal purposes. First, they hoped that $324.5 million could be used to help existing medical schools carry out expansion and modernization plans, which would raise their capacity by 1,060 students. If another $128 million could be used by 16 universities now lacking medical schools to establish two-year schools of basic medical sciences, they could supply 760 students a year to fill places opened in regular medical schools by dropping out of students after a year or two of study. The sum of $540 million would go for establishment of 18 new four-year medical colleges with potential graduating classes of 100 each, to supply the remainder of the additional medical personnel required by 1975. To meet needs for additional dentists, the Senate consultants estimated that $46.5 million for modernizing and expanding existing dental schools would produce 500 more graduates a year, and $132 million would pay for establishment of 22 new schools to graduate 100 students each.

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[12] American Nurses' Association, *Facts About Nursing* (1960), p. 81.

SCHOOLS' PRESSING NEED FOR MORE RESEARCH SPACE

Hand in hand with the need for more teaching space is the continuing demand for more research facilities in medical schools. The Health Research Facilities Act of 1956 set up a three-year program, later extended for three additional years, which authorized federal grants for construction and equipment of research facilities. Appropriations up to $30 million a year were authorized for grants to non-federal institutions on a 50-50 matching basis. Among institutions which have received such grants are 72 medical schools, 15 dental schools, five schools of public health, two schools of osteopathy, a number of hospitals associated with medical schools, and other schools with research programs in veterinary medicine, pharmacy, chemistry and the biological sciences.

Despite the growth of medical school facilities under the grant system, the need for additional research space has not been filled. According to an official of the University of Michigan Medical School, shortage of research space is not only "materially lengthening the time when significant advances will be made in conquering some of our serious diseases, such as cancer and . . . heart disease," but is also adversely affecting the quality of medical education. "It is impossible to draw any sharp line between research and teaching in a university. It is only when a graduate student can serve as an apprentice to an expert investigator having available adequate space and equipment that he will be properly trained." [18]

Because some educational institutions eligible for research construction grants are having difficulty raising outside funds, the consultants to the Senate Appropriations subcommittee recommended that the 50-50 requirement be modified for institutions with urgent space needs and little prospect of attracting non-federal funds. The consultants also recommended a further five-year extension of the Health Research Facilities Act with an amendment to permit grants for multi-purpose facilities combining research with education.

Beyond amassing funds for needed construction, many medical schools have difficulty in meeting their operating expenses. The Surgeon General's Consultant Group esti-

[18] W. J. Nungester, letter reprinted in House Appropriations subcommittee hearings, p. 1145.

mated that the $175 million spent in 1958 for basic operations of the country's medical schools was almost triple the sum laid out for this purpose in 1948 in terms of constant dollar values.

Problems in Meeting Schools' Operating Expenses

State and local governments in 1958 contributed $68 million for basic operations compared with $18 million in 1948. Gifts, grants and endowment income had risen from $12 million to $32 million, and income from tuition was up from $547 million to $773 million. While no federal money has been designated for direct support of basic operations of medical schools, a number of federal training grants in effect provide some support of this kind. Nearly every medical school has received undergraduate training grants awarded by the national cancer, heart, and mental health institutes for a maximum of $25,000 each, and the Public Health Service also finances an experimental program for improvement of medical student training in research methods.

Of major significance to medical school financing are the increasing sums awarded for research activities. Of the total of $264 million spent by the medical schools in 1958, $88 million was for grant-supported research. But the research grants do not cover full costs of the projects. When the number of research grants was small, the institutions could absorb their indirect costs with little difficulty, but now that grant research has become an important part of medical school activity, the once-hidden costs are becoming formidable.

The consultants to the Senate Appropriations subcommittee said the failure of granting agencies to pay full costs of the research was a "deterrent to the further expansion of medical research" and was shortchanging the educational programs of the schools.

> The difference between the actual costs and the percentage paid by the granting agency has had to be met from the institution's own funds. Since most schools of medicine, dentistry and public health are having difficulty financing the rapidly mounting costs of medical education, funds for research can be provided only at the expense of other programs. . . . The burden of the cost of research on the schools has reached such serious proportions that some measure of relief has become the most important single need in the minds of medical educators and administrators.[14]

[14] Committee of Consultants on Medical Research, *op. cit.*, p. 15.

The Consultant Group to the Surgeon General noted that "If all agencies supporting research were to provide for the full cost thereof, the problems of medical schools in providing for basic operations would be materially lessened." [15] Concern was expressed by the consultants over what they considered the serious problem of certain "underfinanced schools." These are institutions which depend on part-time or volunteer faculties, sponsor little research and have meager postgraduate programs. "The underfinanced schools are hard pressed to maintain an educational program within the minimal requirements. Continued underfinancing of some of the medical schools will make it impossible for [them] . . . to meet desirable standards of medical education."

Causes of Shortages: Proposed Remedies

EXPANSION of educational facilities will not assure an adequate supply of skilled medical practitioners unless accompanied by effective measures to attract top quality students in larger numbers to the arduous study of medicine.

Over the past generation there have been about two applicants for each freshman opening in the country's medical schools—except in the immediate postwar years when the ratio reached a peak (1948-49) of 3½:1. The number of applicants relative to the size of the 20-year-old population (one in every 150) has remained constant since the playing out of the postwar boom. But the Surgeon General's Consultant Group found that "While there are more applicants than places, many schools are having serious difficulty in filling their first-year places with well-qualified students." This is indicated not only by scores on admission tests but also by the number of failures, which largely accounted for a rise in first-y · withdrawals from 5.5 per cent in 1954-55 to 7.8 per cent in 1957-58.

High and Increasing Costs of Medical Education

A serious obstacle to improvement in quantity and quality of student bodies is the high cost of a medical education. Not only are the medical student's tuition fees

[15] Consultant Group on Medical Education, *op. cit.*, p. 48.

higher than those for other graduate training, but the demanding courses of study make it difficult for him to take on much outside employment. Some medical schools forbid outside work during the school term. In many instances the student must incur the additional expense of going to a college far away from home where he will have to pay for room and board.

There is little likelihood that tuition fees will fall and considerable likelihood that they will rise. Despite a marked increase in tuition charges over the years, income from this source now covers only 13 per cent of the basic operating expenses of American medical schools, compared with 23 per cent in 1948 and 32 per cent in 1941.

Recent studies show that the average outlay for tuition, other fees, room and board is $2,386 a year for unmarried students and $3,271 for married students. Expenses at the tax-supported schools run a few hundred dollars less—tuition averaging $500 a year against $1,000 for private schools—but residents of states which lack public medical schools have little opportunity to avail themselves of the lower charges.[16] Contributing to the high cost of a medical education is the long period that elapses before the student can establish a private practice. After completing the four-year medical course, he must spend from three to five years as intern and hospital resident.

Stipends for interns average less than $2,300 a year, for resident physicians $3,000. Many are likely to have dependents to support even before they graduate. A canvass of medical school students graduated in 1959 showed that three-fifths of them were married and one-fourth had two or more children. A survey by the Association of American Medical Colleges disclosed that unmarried students derived 22 per cent of their income from earnings, while married students derived 44 per cent from combined earnings of husband and wife. Parents contributed 60 per cent of the expenses of unmarried students and 35 per cent of the expenses of married students.

The economic barriers to education for medical practice are clearly indicated by the relatively high percentage of medical students (two-fifths) whose families have incomes of $10,000 or more a year. This means that 40 per cent

[16] Nine states have no medical schools: Arizona, Delaware, Idaho, Maine, Montana, Nevada, New Mexico, Rhode Island, Wyoming.

of the potential doctor supply is being drawn from only 8 per cent of the population. However, one-fifth of the students in 1959 were found to be from families with incomes of less than $5,000. Half of the students had contracted debts to finance their educations, and the larger burden of indebtedness had been assumed by students from the poorer families.

While a certain amount of scholarship aid is available, the sums offered in the medical field are generally lower than comparable grants offered for graduate work in other professional fields. Only 10 per cent of all medical students in 1958 had scholarships and the amounts averaged only $500. Scholarships for medical education are rarely granted for first-year study. Many students who might be able to finance the first year hesitate to enter medical school because they lack assurance that they will be able to complete their medical studies.

Greater Help, Earlier Rewards in Other Sciences

The pool from which the medical schools draw qualified applicants is necessarily limited, including only the gifted and hard-working students who have a keen interest in scientific achievement. This is the same pool from which students are drawn to other disciplines—disciplines which offer much quicker rewards than medical training, and for less expenditure of time and money. The successful competition from other fields is indicated by the decline in the proportion of college graduates who apply for enrollment in medical schools: from 6 per cent in the years 1950-52 to 3.9 per cent in 1958.

The financial attractions of careers in other professions are indicated not only by the lower costs of graduate education in those fields, but also by the relative abundance of scholarships, fellowships and opportunities for allied employment. Speaking for the Association of American Medical Colleges, an educator testified:

> The federal government now provides scholarships for every field of education except medicine. During the coming year [1960-61] approximately 10,000 pre-doctoral fellowships in the physical, life and social sciences, psychology, engineering, the arts, the humanities and education will be awarded by four federal agencies [State Department, National Science Foundation, Office of Education, National Institutes of Health]. These fellowships . . . provide a stipend of $1,800 to $2,500 with a $500 allowance for each dependent, plus travel allowance; they pay full tuition

> and in some instances . . . an additional subsidy to the institution. A great many universities provide . . . fellowships and scholarships for Ph.D. candidates in the scientific fields and many of them obtain part-time jobs as assistants on research projects or laboratory assistants in the scientific departments. These jobs fit their training . . . [and there are] good job opportunities available immediately upon graduation.[17]

In view of these facts, it was not surprising that while the number of all graduate students increased 68 per cent in the past six years, the number of medical school applicants declined.

Proposal of Government Scholarships for Able Students

Some educators feel that the problem is not so much to meet the competition from other branches of scientific learning as to enlarge the total pool from which graduate students are drawn. The various branches of scientific activity are now so closely related that to deprive one field of needed talent is to do harm to all. Medical research in particular must continue at a high level if medical education is to continue its advance.

Editorials in the *Journal of the American Medical Association* put stress on awakening the younger pupil's interest in medical education long before he reaches college. They note that the typical junior high school class has a large percentage of boys and girls ambitious to become doctors, but interest palls when the students face the realities of pre-medical school requirements. Doctors are urged to use their influence to eliminate educational softness from the lower schools and to press for more gifted teachers able to inspire bright students to undertake the hard courses necessary to qualify for medical practice. But it is recognized that inspiration and hard work are not enough; that means must be found to lower the financial barriers that stand in the way of talented students from lower-income families.

The Surgeon General's Consultant Group recommended "aggressive action" by all agencies, public and private, to supply both loans and scholarships for eligible students who would not otherwise be able to afford a medical education. The federal government, it said, should "establish educational grants-in-aid for medical students on the

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[17] Dr. Robert C. Berson (Medical College of Alabama, Birmingham), testimony before House Commerce subcommittee, June 6, 1960.

basis of merit and need, similar in value and proportionate in number to grants now made to graduate students in other fields of specialization."

A bill introduced in Congress by Rep. John E. Fogarty (D R.I.) proposed appropriations of $5 million the first year and $10 million in each of the nine ensuing years for grants to states administering medical-dental scholarship programs. The federal government would put up one-half of scholarship grants not exceeding $1,250 a year. A "position paper" made public by Vice President Nixon, Oct. 2, proposed a new system of medical fellowships to be awarded on the basis of competitive examinations and individual need. A part of each money award would go to the medical school, the remainder to the student in the form of a low-interest, long-term government loan.

The Eisenhower administration has opposed legislation for separate scholarship assistance to medical students, contending that such aid is now available to all needy students through the loan program authorized by the National Defense Education Act. In a letter to Chairman Oren Harris (D Ark.) of the House Commerce Committee, Secretary of Health, Education and Welfare Arthur S. Flemming wrote that while the need to equalize educational opportunity in order to expand enrollments was recognized, "the general picture is not yet one of vacant places in medical schools." Therefore, federal money in modest amounts should be directed solely to the area of first priority: expansion of the medical schools' training capacity. Flemming went on to raise another and more basic objection to the scholarship plan:

> The institution of a program of direct grants for student assistance in this one field . . . would establish a new precedent for federal policy on higher education. Although there are a number of federal programs which provide student support in advanced and specialized fields . . . these have been predicated . . . on an acute national need for particular kinds of personnel. . . . Thus it would be a major departure from established policy to begin a categorical program of federal financial participation in scholarship grants to students in selected fields of basic training and, although the fields of training in question may be vitally important, we believe this course should be considered only after other possibilities for reducing the burdens of time and expense have been fully explored.[18]

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[18] Letter printed in hearings of House Commerce Committee, *Medical and Dental Schools* (1960), p. 16.

The American Medical Association has modified its traditional opposition to federal aid by approving "one-shot" grants for medical school construction, but it has taken no stand on federal scholarships. The association's House of Delegates last year authorized a committee to draw up an A.M.A. scholarship program, and constituent medical societies have long granted a limited number of scholarships. A member of the A.M.A. board of trustees recently suggested that the profession "reconsider its attitude toward government support of education" in view of the shortage of private funds for this purpose and medicine's need "to attract its required share of . . . superior students." [19]

The question whether medical education is being unduly prolonged has been raised in this connection. The A.M.A. trustee quoted above has asked: "Are medical schools teaching obsolescent facts and procedures which might well be eliminated? . . . Is the internship necessary? . . . Is the present trend to continually lengthen the specialty residency training program sound?" Even the rigid adherence to a four-year basic program, it has been pointed out, may be out of keeping with changed methods of education and medical practice, while the protracted training for specialists insisted upon by the specialty boards may constitute an inefficient use of medical manpower.

[19] James Z. Appel, *Journal of the American Medical Association*, Feb. 8, 1960, p. 1446.